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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **BRIDGET ARNELL LEMOS** **P.O. Box 2825** **Gardena, CA 90245** **Registered Nurse License No. 671408** Respondent.	Case No. 2013-760 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about January 3, 2006, the Board issued Registered Nurse License Number 671408 to Bridget Arnell Lemos ("Respondent"). The Registered Nurse License will expire on January 31, 2014, unless renewed.

JURISDICTION

3. Section 2750 of the Business and Professions Code (all section references are to the Business and Professions Code unless otherwise noted) in pertinent part provides the Board may

discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. In pertinent part, Section 2764 provides the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under section 2811 subdivision (b) the Board may renew an expired license at any time within eight years after the expiration.

5. Section 118 subdivision (b) grants the Board jurisdiction over suspended, expired, forfeited, cancelled, or surrendered licenses:

> "The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

STATUTES

6. In pertinent part, Section 2761 authorizes the Board to discipline licensees for unprofessional conduct and gross negligence:

> "The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. Section 2762 authorizes the Board to discipline licensees for unprofessional conduct involving controlled substances:

> "In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> "(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

8. Section 4022 defines "dangerous drug" to include any prescription drug:

"'Dangerous drug' or 'dangerous device' means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.

(b) Any device that bears the statement: 'Caution: federal law restricts this device to sale by or on the order of a ____,' 'Rx only,' or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

REGULATIONS

9. Title 16 section 1442 of the California Code of Regulations defines gross negligence for purposes of the Nursing Practice Act:

"As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

CONTROLLED SUBSTANCES

10. Hydromorphone, also known by the brand name Dilaudid, is a Schedule II controlled substance as defined in Health and Safety Code section 11055, subdivision (b)(1)(j) and is categorized as a dangerous drug pursuant to section 4022.

COST RECOVERY

11. In pertinent part, Section 125.3 authorizes the Board to request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case and authorizes the recovery of those costs in any settlement agreement.

/ / /

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

12. Respondent is subject to discipline pursuant to Section 2761 subdivision (a)(1) on the grounds of gross negligence as defined in title 16 section 1442 of the California Code of Regulations because she gave a patient an overdose of hydromorphone and attempted to cover-up her mistake, causing the patient severe harm. The facts are as follows:

13. In April 2009, Respondent was a registered nurse in the Medical/Surgical Unit at California Hospital Medical Center in downtown Los Angeles.

14. On or about April 17, 2009, a male patient was admitted to the hospital complaining of severe headaches, abdominal pain, and fever. The patient was treated and his condition improved.

15. The next day, the patient was due to be discharged, but complained of severe headache pain. A physician discontinued the patient's morphine prescription and ordered that the patient be given 2 milligrams of hydromorphone instead. Respondent was to administer the hydromorphone to the patient.

16. Hydromorphone comes in different concentrations and dosages. For the prescription given, Respondent should have withdrawn from the medication dispensing machine a cartridge containing 2 milligrams of hydromorphone per cubic centimeter. Instead she withdrew a vial containing 10 milligrams of hydromorphone per cubic centimeter, a much higher concentration.

17. Taking the hydromorphone from the vial instead of the cartridge, Respondent went to the patient's room where the patient was resting with his wife and daughter. She then administered an overdose of hydromorphone to the patient.

18. Immediately after Respondent administered the hydromorphone, the patient's wife heard Respondent say "oh shit." Respondent then left the patient's room and went to the cafeteria for lunch.

19. Several minutes after the injection, the patient's wife and daughter saw the patient start to turn purple and stop talking. He was in respiratory arrest. They called for help. Nurses

came running, including Respondent. Someone called a "code blue," a signal there was an emergency. A physician and rapid response team came shortly after.

20. Respondent did not alert the other nurses or the physician about the possible overdose of hydromorphone. Had she done so, they could have administered Narcan, a medication to potentially reverse the effects of the hydromorphone.

21. The patient suffered a severe brain injury as a result of his respiratory arrest. He was left in a permanent vegetative state.

22. Respondent attempted to cover-up her mistakes through false statements and false entries in the medical records.

23. First, Respondent failed to timely document her withdrawal of the hydromorphone from the dispensing machine, as required by hospital's policies and procedures. After the code blue, she attempted to conceal her medication error by documenting after the fact that she had withdrawn the vial containing 10 milligram per cubic centimeter of hydromorphone but only administered 2 milligrams from it. She claimed she had wasted -- disposed of -- the rest. Since hospital policy required that another nurse witness the wastage of this type of medication, she asked another nurse to falsely claim to have witnessed the wastage.

24. Second, Respondent made false entries on the patient's pain management flowsheet that showed that after receiving the Dilaudid (hydromorphone) the patient's pain had been reduced from a 9 on a 10-point scale to a 2. In fact, at the time the Respondent charted the patient's pain as "2 / 10", the patient was in a coma after respiratory arrest and unable to communicate about his pain level.

25. Third, Respondent falsified records indicating that the patient had been administered Narcan during the code blue. The patient did not receive this medication, but should have.

25. Fourth, Respondent falsely wrote that she waited at the patient's bedside for 10 minutes after administering the hydromorphone. She did not.

26. Respondent's treatment of this patient, including her administration of an overdose of hydromorphone, her failure to alert others about the overdose to allow them to take appropriate remedial measures, and her cover-up of her errors through her false entries on medical records

were an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Her errors jeopardized her patient's health and life, contributing to his severe and permanent injury.

SECOND CAUSE FOR DISCIPLINE

(False Entries)

27. Respondent is also subject to discipline pursuant to Section 2762 subdivision (e) on the grounds of unprofessional conduct for making false entries and grossly incorrect entries in hospital or patient records pertaining to hydromorphone, a controlled substance and dangerous drug and Narcan,

28. Paragraphs 12 through 26 are incorporated into and realleged in this cause for discipline.

29. Respondent made the following false and grossly incorrect entries in the hospital and patient record:

a) In the controlled drug disposition record she had another nurse witness the wasting of hydromorphone that the other nurse had not seen wasted;

b) In the patient's pain management flowsheet she falsely recorded a reduction in the patient's pain level at a time where the patient was comatose;

c) In the patient's chart, she falsely recorded she had waited 10 minutes with the family after administering the hydromorphone; and

d) In the event report for the code blue, she falsely recorded that .4 mg of Narcan had been given, when it had not.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

30. Respondent is also subject to discipline pursuant to Section 2761 subdivision (a) for unprofessional conduct.

31. Paragraphs 12 through 26 are incorporated into and realleged in this cause for discipline.

32. Respondent's treatment of this patient, including her administration of an overdose of hydromorphone, her failure to alert others about the overdose to allow them to take appropriate remedial measures, and her cover-up of her errors through her false entries on medical records constitute unprofessional conduct as well as gross negligence.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 671408, issued to Bridget Arnell Lemos;

2. Ordering Bridget Arnell Lemos to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code Section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: March 14, 2013

for LOUISE R. BAILEY, M.Ed., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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